FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042374

Facility Name: Mariner Health of Westchester

Address: 2901 S. Wolf Road (Number) Westchester (City) 60154 (Zip Code)

County: Cook

Telephone Number: (708) 531-1441 **Fax #** (708) 409-1271

IDPA ID Number: 58-1398665001

Date of Initial License for Current Owners: 10/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry DeBons **Telephone Number:** (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Linda Holtzscheiter

(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) N/A

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,536	13,857	9,396	34,789	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,536	13,857	9,396	34,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.43%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1-/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 120 and days of care provided 8,286

Medicare Intermediary AdminStar Illinois

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	245,609	23,422	23,761	292,792		292,792		292,792			1
2	Food Purchase		170,696		170,696		170,696	(408)	170,288			2
3	Housekeeping	109,179	20,607	36,975	166,761		166,761		166,761			3
4	Laundry	40,464	9,845	28,185	78,494		78,494		78,494			4
5	Heat and Other Utilities			101,991	101,991		101,991	36	102,027			5
6	Maintenance	36,441	85,292	21,587	143,320		143,320	91	143,411			6
7	Other (specify):* Waste/ garbage -See Pg 3.1			31,944	31,944		31,944		31,944			7
8	TOTAL General Services	431,693	309,862	244,443	985,998		985,998	(281)	985,717			8
	B. Health Care and Programs											
9	Medical Director			24,300	24,300		24,300		24,300			9
10	Nursing and Medical Records	1,871,998	176,368	271,121	2,319,487		2,319,487	14,863	2,334,350			10
10a	Therapy	164,462	3,119	72,608	240,189		240,189		240,189			10a
11	Activities	61,683	4,053	1,078	66,814		66,814	188	67,002			11
12	Social Services	29,893		188	30,081		30,081		30,081			12
13	Nurse Aide Training											13
14	Program Transportation			12,572	12,572		12,572		12,572			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,128,036	183,540	381,867	2,693,443		2,693,443	15,051	2,708,494			16
	C. General Administration											
17	Administrative	77,164			77,164		77,164		77,164			17
18	Directors Fees											18
19	Professional Services			4,196	4,196		4,196	8,976	13,172			19
20	Dues, Fees, Subscriptions & Promotions			85,113	85,113		85,113	(1,741)	83,372			20
21	Clerical & General Office Expenses	233,115	15,350	324,104	572,569		572,569	(102,339)	470,230			21
22	Employee Benefits & Payroll Taxes			445,754	445,754		445,754		445,754			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,610	8,610		8,610	13,365	21,975			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,583	106,583		106,583	(33,864)	72,719			26
27	Other (specify):*											27
28	TOTAL General Administration	310,279	15,350	974,360	1,299,989		1,299,989	(115,603)	1,184,386			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,870,008	508,752	1,600,670	4,979,430		4,979,430	(100,833)	4,878,597			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mariner Health of Westchester #0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			207,789	207,789		207,789	126,784	334,573			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			559,736	559,736		559,736	51	559,787			32
33	Real Estate Taxes			265,288	265,288		265,288	416	265,704			33
34	Rent-Facility & Grounds							2,825	2,825			34
35	Rent-Equipment & Vehicles							6,468	6,468			35
36	Other (specify):* See Pg 4.1			11,811,098	11,811,098		11,811,098	(11,796,681)	14,417			36
37	**TOTAL Ownership**			12,843,911	12,843,911		12,843,911	(11,660,137)	1,183,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,763	450	322,213		322,213		322,213			39
40	Barber and Beauty Shops			25,944	25,944		25,944	(25,944)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,340	65,340		65,340		65,340			42
43	Other (specify):* See Pg 4.1			5,525	5,525		5,525		5,525			43
44	**TOTAL Special Cost Centers**		321,763	97,259	419,022		419,022	(25,944)	393,078			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,870,008	830,515	14,541,840	18,242,363		18,242,363	(11,786,914)	6,455,449			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(408)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	51	32		10
11	Discounts, Allowances, Rebates & Refunds	36	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(134,047)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(281)	20		28
29	Other-Attach Schedule	(11,903,532)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,038,181)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	251,267		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 251,267		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ##########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Mariner Health of Westchester

ID# 0042374

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (4,486)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	0	21	3
4	Depreciation Reconciliation	89,336	30	4
5	Activities Program Receipts	188	11	5
6	Depreciation Reconciliation	37,448	30	6
7	Professional Liability Insurance	(34,594)	26	7
8	Barber & Beauty	(25,944)	40	8
9	Public Relation Expense	0	20	9
10	Non Allowable Advertising	(2,573)	20	10
11	Entertainment	(27)	24	11
12	Fresh Start	(11,811,098)	36	12
13	Penalities	0	21	13
14	Vending Reciepts	0	21	14
15	Misc Reciepts	0	21	15
16	Marketing Wages	(58,036)	21	16
17	Maketing Bonus	(998)	21	17
18	Marketing Holiday	(1,815)	21	18
19	Marketing Sick	0	21	19
20	Marketing Vacation	(4,188)	21	20
21	Marketing Overtime	(1,383)	21	21
22	Legal Fees -Bankrupcty	(29,167)	21	22
23	Misc Revenue	(2,258)	21	23
24	Extraordinary Loss	(53,937)	21	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,903,532)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(408)	0	0	0	0	0	0	0	0	0	0	(408)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	36	0	0	0	0	0	0	0	0	0	36	5
6	Maintenance	0	91	0	0	0	0	0	0	0	0	0	91	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(408)	127	0	0	0	0	0	0	0	0	0	(281)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	14,863	0	0	0	0	0	0	0	0	0	14,863	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	188	0	0	0	0	0	0	0	0	0	0	188	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	188	14,863	0	0	0	0	0	0	0	0	0	15,051	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,976	0	0	0	0	0	0	0	0	0	8,976	19
20	Fees, Subscriptions & Promotions	(2,854)	1,113	0	0	0	0	0	0	0	0	0	(1,741)	20
21	Clerical & General Office Expenses	(290,279)	187,940	0	0	0	0	0	0	0	0	0	(102,339)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(27)	13,392	0	0	0	0	0	0	0	0	0	13,365	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(34,594)	730	0	0	0	0	0	0	0	0	0	(33,864)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(327,754)	212,151	0	0	0	0	0	0	0	0	0	(115,603)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(327,974)	227,141	0	0	0	0	0	0	0	0	0	(100,833)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	126,784	0	0	0	0	0	0	0	0	0	0	126,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	51	0	0	0	0	0	0	0	0	0	0	51	32
33	Real Estate Taxes	0	416	0	0	0	0	0	0	0	0	0	416	33
34	Rent-Facility & Grounds	0	2,825	0	0	0	0	0	0	0	0	0	2,825	34
35	Rent-Equipment & Vehicles	0	6,468	0	0	0	0	0	0	0	0	0	6,468	35
36	Other (specify):*	(11,811,098)	14,417	0	0	0	0	0	0	0	0	0	(11,796,681)	36
37	**TOTAL Ownership**	(11,684,263)	24,126	0	0	0	0	0	0	0	0	0	(11,660,137)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(25,944)	0	0	0	0	0	0	0	0	0	0	(25,944)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(25,944)	0	0	0	0	0	0	0	0	0	0	(25,944)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,038,181)	251,267	0	0	0	0	0	0	0	0	0	(11,786,914)	45

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 36	$ 36	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	91	91	2
3	V	19	Professional Services		Mariner Health Care	100.00%	8,976	8,976	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	1,113	1,113	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	14,863	14,863	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	187,940	187,940	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	13,392	13,392	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	445	445	8
9	V	36	Depreciation		Mariner Health Care	100.00%	14,417	14,417	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	416	416	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	6,468	6,468	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	2,825	2,825	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	285	285	13
14	Total			$			$ 251,267	$ * 251,267	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 192	$		$ 36	1
2	6	Repair & Maintenance				556			91	2
3	19	Professional Services				50,336			8,976	3
4	20	Fees, Subscription, Promotions				6,593			1,113	4
5	10	Nursing & Medical Records				675,703			14,863	5
6	21	Clerial & General Office Exp				527,522			187,940	6
7	24	Travel & Seminar				84,515			13,392	7
8	26	Insurance Premium				2,427			445	8
9	36	Depreciation				81,021			14,417	9
10	33	Taxes - Property				2,346			416	10
11	35	Rental & Leasing				35,937			6,468	11
12	34	Lease Expense				15,801			2,825	12
13	26	Property Insurance				1,581			285	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,530	$		$ 251,267	25

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	254,138	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	250,851	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,287)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	268,575	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	265,288	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	242,542	8
1998	243,979	9
1999	242,963	10
2000	245,247	11
2001	250,851	12

Line 1 adjusted or not equal to prior C/R due to intercompany entries.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mariner Health of Westchester COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042374

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-29-300-018-0000	2901 S Wolf Rd. Westchester	$ 250,851.17	$ 250,851.17
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 250,851.17	$ 250,851.17

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,531 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1989	$ 795,000	1
2					2
3	TOTALS			$ 795,000	3

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1989	1989	$ 4,412,330	$ 110,308	40	$ 110,308	$	$ 772,157	4
5			1991	1991	217,404	5,435	40	5,435		38,045	5
6			1993	1993	15,459	386	40	386		2,703	6
7			1994	1994	14,498	1,216	40	1,216		8,511	7
8			1995	1995	2,902	73	40	73		510	8
	Improvement Type**										
9	Tile			1996	2,092	53	40	53		333	9
10	Caparting			1996	2,118	303	7	303		1,943	10
11	Drywall			1996	1,200	30	40	30		204	11
12	Building IMP/APCO			1996	4,439	111	40	111		740	12
13	Booster Heater Upgrade			1996	2,810	401	7	401		2,641	13
14	Repair of washer			1996	1,671	239	7	239		1,533	14
15	Plumbing Repair			1996	5,328	761	7	761		4,717	15
16	Healthcare Design			1997	6,896	172	40	172		904	16
17	Wallcoverings			1997	55,860	1,395	40	1,395		7,192	17
18	Draperies			1997	66,932	9,562	7	9,562		50,367	18
19	Painting & Decorating			1997	14,813	372	40	372		1,920	19
20	Carpeting			1997	38,524	5,505	7	5,505		28,881	20
21	Building Unterior Design - Nrsng & Therapy Rooms			1997	50,274	1,257	40	1,257		6,600	21
22	Phone System			1998	33,091	6,618	5	6,618		31,436	22
23	Building Unterior Design - Nrsng & Therapy Rooms			1998	52,903	1,323	40	1,323		6,211	23
24	Construction & Renovation - Nrsing & Therapy Rooms			1998	139,140	349	40	349		17,192	24
25	Heat Air Units			1998	2,239	320	7	320		1,573	25
26	Heat Air Units			1998	1,120	160	7	160		787	26
27	Window Treatments			1998	1,518	217	7	217		1,013	27
28	Cubicle Curtains			1998	1,180	169	7	169		718	28
29											29
30	Mariner Health Allocation			1993	111	7	15	7		103	30
31	Mariner Health Allocation			1995	21,658	637	40	637		5,841	31
32	Mariner Health Allocation			1996	3,321	213	'7-40	213		1,617	32
33	Mariner Health Allocation			1997	1,118	29	'7-40	29		175	33
34	Mariner Health Allocation			1998	2,905	55	'7-40	55		275	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heat Exchange Install	1999	$ 748	$ 19	40	$ 19	$	$ 673	37
38	Heat Exchange Install	1999	6,223	156	40	156		5,600	38
39	Interior Design Serv	1999	150	4	40	4		135	39
40	Flooring -Dining Room	2000	1,065	106	10	106		284	40
41	Flooring -Resident Rooms	2000	2,127	213	10	213		567	41
42	Vinyl Tile Resident	2000	4,004	400	10	400		1,068	42
43	Vinyl Tile Dining	2000	2,064	206	10	206		550	43
44	Vinyl Flooring	2000	1,136	227	5	227		511	44
45	VCT W/ Wallbase	2000	2,650	265	10	265		596	45
46	Zone Air HVAC Unit, PT Rm 225	2001	1,850	123	15	123		257	46
47	3: Zoneline HVAC Units	2001	5,700	380	15	380		728	47
48	3: A/C Compressor, RM 16A,& B, Rm 17A	2001	5,700	380	15	380		602	48
49	Rooftop Condenser Coil- Kitchen	2001	3,880	259	15	259		366	49
50	Rpr Compressor, Leaks -F/A System	2001	3,800	380	10	380		507	50
51	Roof Repair - Kitchen & Rm 226	2001	833	83	10	83		111	51
52									52
53	Replc Transfer Switch/Generator	2002	3,100	129	20	129		129	53
54	Restore/ Clean Concrete Ramps	2002	3,650	133	15	133		133	54
55	Zoneline Heat/Cool Unit & Use Tax	2002	759	76	5	76		76	55
56	A.O. Smith Water Heater -Instl	2002	5,800	242	10	242		242	56
57	Compressor Repr -A/C	2002	2,837	95	15	95		95	57
58	12: Door Closers Instl	2002	4,605	128	15	128		128	58
59	R Carpet w/Tile (1/3 Deposit)	2002	12,526	522	10	522		522	59
60	Roof Rep (Bal Due)	2002	4,388	475	10	475		475	60
61	Vinyl Tile Entry Corridor (25% pmt)	2002	7,000	117	10	117		117	61
62	Floor tile Instl -corridor (2nd pmt)	2002	11,000	183	10	183		183	62
63	Credit - W/G Equipment	2002	(250)	(4)	10	(4)		(4)	63
64	2: Repeaters	2002	1,125	19	10	19		19	64
65	Credit - W/G Discount	2002	(173)	(1)	10	(1)		(1)	65
66	Wanderguard system Instl	2002	46,819	780	10	780		780	66
67	Tile Flooring (pmt #3)	2002	5,000	42	10	42		42	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,325,967	$ 153,811		$ 153,811	$	$ 1,012,332	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,041,183	$ 146,313	$ 146,313	$	var	$ 804,880	71
72	Current Year Purchases	86,931	34,449	34,449		var	34,449	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,128,114	$ 180,762	$ 180,762	$		$ 839,328	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,249,081	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 334,573	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 334,573	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,851,660	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 0 Description: None
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Mariner Health of Westchester STATE OF ILLINOIS # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1733	hrs	$ 39,258	2,604	$ 22,150	$ 0	4,337	$ 61,408	1
2	Licensed Speech and Language Development Therapist	10a		hrs		1,912	21,042	0	1,912	21,042	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2027	hrs	80,739	2,208	11,592	1,631	4,235	93,962	4
5	Physician Care			visits							5
6	Dental Care	39		visits			75			75	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				236,180		236,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Va Physicain	39					375			375	13
14	TOTAL				$ 119,997	6,724	$ 55,234	$ 237,811	10,484	$ 413,042	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 600	$	1
2	Cash-Patient Deposits	8,565		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	942,274		3
4	Supply Inventory (priced at)	12,794		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	557,114		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,521,347	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	132,710		11
12	Long-Term Investments			12
13	Land	850,000		13
14	Buildings, at Historical Cost	4,514,084		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	181,618		16
17	Accumulated Depreciation (book methods)	(134,508)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	227		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,544,131	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,065,478	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 105,028	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,156		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,710		31
32	Accrued Real Estate Taxes(Sch.IX-B)	268,575		32
33	Accrued Interest Payable	(1,265)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schd 17.1	85,343		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 586,547	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached Schd 17.1	5,281,273		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,281,273	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,867,820	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,197,658	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,065,478	$	48

*(See instructions.)

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,163,295	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,163,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(11,696,763)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (11,696,763)	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**	6,731,126	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 6,731,126	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,197,658	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,778,321	1
2	Discounts and Allowances for all Levels	(2,218,547)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,559,774	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	728,499	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 728,499	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	34,191	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	9,380	15
16	Rental of Facility Space		16
17	Sale of Drugs	830,362	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	189,250	19
20	Radiology and X-Ray		20
21	Other Medical Services	192,420	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,255,603	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts		28
28a	Miscellanceous Receipts	1,724	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,545,600	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	985,998	31
32	Health Care	2,693,443	32
33	General Administration	1,299,989	33
	B. Capital Expense		
34	Ownership	12,843,911	34
	C. Ancillary Expense		
35	Special Cost Centers	353,682	35
36	Provider Participation Fee	65,340	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,242,363	40
41	**Income before Income Taxes (line 30 minus line 40)****	(11,696,763)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (11,696,763)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,874	5,328	$ 153,075	$ 28.73	1
2	Assistant Director of Nursing	1,195	1,306	37,292	28.55	2
3	Registered Nurses	15,431	16,870	428,633	25.41	3
4	Licensed Practical Nurses	16,356	17,881	360,366	20.15	4
5	Nurse Aides & Orderlies	62,973	68,844	855,408	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,760	4,082	109,084	26.72	7
8	Rehab/Therapy Aides	3,231	3,507	55,377	15.79	8
9	Activity Director	1,919	2,182	26,177	12.00	9
10	Activity Assistants	3,403	3,870	35,506	9.17	10
11	Social Service Workers	1,582	1,956	29,893	15.28	11
12	Dietician					12
13	Food Service Supervisor	1,804	1,985	37,531	18.91	13
14	Head Cook	6,442	7,085	80,233	11.32	14
15	Cook Helpers/Assistants	14,912	16,401	127,845	7.79	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,172	36,441	16.78	17
18	Housekeepers	11,919	12,505	109,179	8.73	18
19	Laundry	4,684	4,892	40,464	8.27	19
20	Administrator	2,109	2,330	87,994	37.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,982	11,028	155,864	14.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	959	1,063	15,506	14.59	31
32	Other Health Ca MCare Coord/ Ca	1,875	2,050	21,719	10.59	32
33	Other(specify) Mkting & Transpo	2,870	3,270	66,421	20.31	33
34	TOTAL (lines 1 - 33)	174,265	190,607	$ 2,870,008 *	$ 15.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	549	$ 21,996	1 - 3	35
36	Medical Director	96	24,300	9 - 3	36
37	Medical Records Consultant	96	4,128	10-3	37
38	Nurse Consultant	326	14,863	10- 7	38
39	Pharmacist Consultant	271	11,650	10 - 3	39
40	Physical Therapy Consultant			10a-03	40
41	Occupational Therapy Consultant			10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a-03	43
44	Activity Consultant	25	1,316	11 - 3	44
45	Social Service Consultant	4	188	12 - 3	45
46	Other(specify) Nurse Consultant	120	28,328	10 -03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,487	$ 106,769		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	152	$ 6,906	10 - 3	50
51	Licensed Practical Nurses	3,057	106,607	10 - 3	51
52	Nurse Aides	5,182	108,705	10 - 3	52
53	TOTAL (lines 50 - 52)	8,391	$ 222,218		53

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra l. Gourley	Adminsrtator	100	$ 23,575
Connie Trunk	Adminsrtator	100	42,818
Sandra Boland	Adminsrtator	100	10,771
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,164

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal (SEE ATTACHED)	Legal Fees	4,196
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,196

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,423
Unemployment Compensation Insurance	28,935
FICA Taxes	214,250
Employee Health Insurance	85,825
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension/Retirement	3,471
Insurance Life	3,490
Other Benefits	3,361
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 445,754

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	68,714
Health Care Worker Background Check	
(Indicate # of checks performed)	4,857
Other Licenses Fees	1,975
Dues	5,008
Home Office Allocation	1,113
Total Advertising	4,675
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,394)
Yellow page advertising	(281)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 81,667

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,117
In-State Travel	5,578
Home Office Allocation	13,392
Seminar Expense	1,916
Entertainment Expense	(27)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,976

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mariner Health of Westchester # 0042374 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $ 4,680**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,711** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,340**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name & ID Number Mariner Health of Westchester # 0042374 Ending: 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	0
Infectious Waste Disposal <> Default <> Physical Plant	15,790
Garbage Service <> Default <> Physical Plant	16,154
	31,944

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Mariner Health of Westchester # 0042374 Ending: 12/31/2002

Meals - adjustment

34,789	Days (Total Patient days)
3	Mult (3 meals a day)
104367	Sub total
250	meals to employess (reported by facility)
104617	Add Sub
170,696	Divide -Pg 3, line 2, column 2
1.63	Cost per meal

1.63	Cost per day
250	mult - meal to employees
408	= adjust for pg 2, line 2, column2

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	11,811,098
Home Office - Depreciation	14,417
	11,825,515

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Supplies <> Default <> Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Contract Svcs - Chgbl <> Default <> Laboratory	5,525
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	5,525

Related Illinois Nursing Homes as of 12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

Line 9

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

Line 36

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	(292)
Misc Dedctns - Employee <> Union Dues <> Default	(99)
Accruals - Insurance <> Accrue HMO Ins <> Default	(1,112)
Accruals - Insurance <> Self Funded Ins Accr <> Default	(13,208)
Accruals - Insurance <> Basic Life <> Default	(966)
Accruals - Insurance <> Lt Dsblty <> Default	(225)
Accruals - Insurance <> Executive Supp Life <> Default	(335)
Accruals - Insurance <> Short Term Disability <> Default	(426)
Accruals - Insurance <> Dependent Life <> Default-Dept	(9)
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	(7)
Accruals - Insurance <> NES Insurance <> Default-Dept	(1,467)
Misc Dedctns - Employee <> Miscellaneous <> Default	-
Deferred Income <> Deferred Revenue-Blood Glucose <> Default	1,257
L/T Debt - Current Portion <> Current Portion <> Default	(68,453)
Total	(85,343)
Reconcile with schedule XV, line 36:	(85,343)
Difference	(0)

Line 23

OTHER NON-CURRENT ASSETS:	
Asset Clearing <> Default-Prod <> Default-Dept	-
Asset Clearing <> Default <> Realty	-
Asset Clearing <> Capital Expenditures <> Realty	-
Asset Clearing <> Fresh Start Valuation <> Realty	-
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-
Other Assets <> Rfndable Deposits-Int Bearing <> Default	-
Excess Reorganized Value <>Excess Reorg Value <> Default	-
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	227
Total	227
Reconcile with schedule XV, line 23:	227
Rounding to bal page	
Difference	-

Line 43

OTHER NON-CURRENT LIABILITIES::	
N/P - Mortgage <> Mortgages <> Default	(5,100,043)
Mortgage Cost <> Current Position <> Default	-
Long Term Debt - Other <> Other <> Default	-
Intercompany - Revolver <> Default <> Default	(181,231)
I/C Term Loan 1998 <> Default-Prod <> Default-Dept	-
I/C Term Loan 1999 <> Default-Prod <> Default-Dept	-
I/C - Interunit Asset Transfer <> Default-Prod <> Default-Dept	-
Compromised Liabilities <> Default	-
Other Non-Current Lby <> Rent Accrual <> Default	-
Other Non-Current Lby <> Other <> Default-Dept	-
Other Non-Current Lby <> Overmarket Lease <> Default-Dept	-
Total	(5,281,273)
Reconcile with schedule XV, line 43:	5,281,273
Difference	(0)

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0

Total	0	Difference
Reconcile with schedule XVII, line 28:	0	0

DESCRIPTIONS	
General Revenue <> (General) <> Other	0.00
General Revenue <> (General) <> Other Misc Rev	(2,258.32)
Personal Purchase Receipts <> Default <> Patient Personal Purchase	(297)
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	950
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	(118)

	-1	Rounding
Total	(1,724)	Difference
Reconcile with schedule XVII, line 28a:	(1,724)	0